**Being targeted: young women's experience of being identified for a teenage pregnancy prevention programme**

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## Abstract

Research on the unintended consequences of targeting 'high-risk' young people for health interventions is limited. Using qualitative data from an evaluation of the Teens & Toddlers Pregnancy Prevention programme, we explored how young women experienced being identified as at risk for teenage pregnancy to understand the processes via which unintended consequences may occur. Schools' lack of transparency regarding the targeting strategy and criteria led to feelings of confusion and mistrust among some young women. Black and minority ethnic young women perceived that the assessment of their risk was based on stereotyping. Others felt their outgoing character was misinterpreted as signifying risk. To manage these imposed labels, stigma and reputational risks, young women responded to being targeted by adopting strategies, such as distancing, silence and refusal. To limit harmful consequences, programmes could involve prospective participants in determining their need for intervention or introduce programmes for young people at all levels of risk.



*Key words:* High-risk; prevention; risk management; targeting; teenage pregnancy; school

## Introduction

The UK Teenage Pregnancy Strategy (1999-2010) (Social Exclusion Unit, 1999; Department for Children Schools and Families (DCSF), 2010) recommended targeting preventative programmes to high-risk individuals and areas. Although the strategy coincided with a decline in the conception rate for under-18s in England and Wales (Arie, 2014; Institute for Fiscal Studies, 2013), the rationale and benefits of targeting remain contested (Bonell & Fletcher, 2008; Institute for Fiscal Studies, 2013; Fletcher, Gardner, McKee, & Bonell, 2012).

Targeting interventions toward individuals or groups with increased risk of an adverse outcome is thought to improve equity, enable more efficient use of resources (Carey & Crammond, 2014; Cerdá, Tracy, Ahem, & Galea, 2014; Kreuter, et al., 2014; Kreuter & Wray, 2003) and focus on the specific problem or individual/group at risk rather than those unlikely to be affected. The approach is, however, criticised for its limited potential impact on incidence at the population-level, and limited recognition of the wider social determinants (Fletcher et al., 2012). Considering teenage pregnancy for example, risk is normally distributed and most pregnancies will arise from the larger group of young women at low or medium risk rather than the smaller group at high risk (Kneale, Fletcher, Wiggins, & Bonell, 2013; Rose, 1992). High-risk strategies, if successful, only result in reducing a fraction of the potential cases in the overall population and require continued intervention with new cases, as overall susceptibility in the population remains unaddressed (Grimes & Schultz, 2002; Rose, 1992).

Targeting also assumes an ability to identify those at high-risk and to distinguish between these individuals and the rest of the population (Grimes & Schultz, 2002; Rose, 1992). Kneale et al. (2013) tested the capacity of targeting, based on indicators of risk, to locate future teenage mothers in three UK cohort study databases and found that this group is difficult to identify thus targeted

interventions would not reach the majority of young women who would become teenage parents.

There may be unintended consequences for individuals who are targeted. For example, interventions that identify young people as 'at risk' may lead to negative self-perception or 'labelling' (e.g., naughty, problematic) and the associated stigma attributed to the label (Goffman, 1959, 1963). The approach may also inadvertently lower young people's expectations and engender poor behaviour and outcomes (Evans, Scourfield, & Murphy, 2014; Rorie, Gottfredson, Cross, Wilson & Connell, 2011; Wiggins et al., 2009; Bonell & Fletcher, 2008; Weiss et al., 2005; McCord, 2003; Dishion, McCord, & Poulin, 1999). A qualitative exploration of a social and emotional learning intervention with students aged 12-14 in secondary schools in Wales identified four unintended effects related to targeting criteria and composition of the intervention groups: negative labelling, elevation of status among targeted (poorly behaved) students, marginalisation of unknown peers in mixed groups, and amplification of deviancy within friendship groups (Evans et al., 2014). This experience of targeting, labelling and stigma, particularly in formal systems of intervention, may have long-term repercussions rooted in a young person's inability to overcome having been categorised, and having internalised, a negative label (Creaney, 2012).

Stigma is associated with sexual health outcomes, such as sexually transmitted infections (STIs) (Foster & Byers, 2013; Balfe et al., 2010) and teenage pregnancy (SmithBattle, 2013; Weimann, Rickert, Berenson, & Volk, 2005) leading to worries about judgment, guilt, shame and rejection among those who experience it. Being considered at high-risk for teenage pregnancy or to be singled out for a teen-pregnancy intervention may provoke similar sentiments among young women identified. While previous studies provide important evidence on the unintended consequences of targeting, none capture the nature of the experience from the perspective of the young people considered at risk. Examination of the meaning of the experience of being targeted may facilitate an understanding of why the approach results in unintended effects. Interpretive phenomenological analysis seeks to illuminate the lived experience of a phenomenon by

interrogating the perceptions of individuals who experienced the same phenomenon. In general, a phenomenological approach aims to address two central questions: What was experienced? and What contexts or situations have influenced or affected the experience? In doing so, the approach investigates the significance of an experience, in contrast to examining the consequences (Smith, Flowers, & Larkin, 2012; Moustakas, 1994; van Manen, 1990). In this research, we explore via a phenomenological approach, the experience of being targeted for the Teens & Toddlers teenage pregnancy prevention programme (T&T): What it felt like to be deemed at risk of teenage pregnancy; and, how the process of selection influenced the meaning of the experience, from the perspective of the young women who were selected to participate in the T&T programme.

## Methods

To explore young women's lived experience of being targeted, we drew on qualitative data from the evaluation the T&T intervention.

### The intervention

Teens & Toddlers is a teenage pregnancy prevention programme that aimed to "decrease teenage pregnancy by raising the aspirations and educational attainment of 13-17 year old teenagers at most risk of leaving education early, social exclusion and becoming pregnant" (Teens & Toddlers, 2008). The programme had three components: a classroom-based curriculum focussed on the development of interpersonal skills, healthy parenting and sexual health, and including weekly journaling; mentoring a child between the ages of 3-5 years old in need of extra attention in a nursery or primary school setting for one to two afternoons a week; and one-to-one hour-long sessions with a trained counsellor over the course of 18-20 weeks (Sorhaindo et al., 2009).

**The targeting strategy**

Schools were recruited from areas with high rates of teenage pregnancy. To identify potential participants for the intervention, school staff responsible for pastoral care or inclusion compiled a list of year 9 or 10 (aged 13-14) students whom they believed were at risk of teenage pregnancy. To assist with this process, T&T provided school staff with a 'selection tool' or checklist of factors related to a young person's personality, behaviours, and background, which the T&T programme believed indicated risk of teenage pregnancy (Sorhaindo et al., 2009). At the time of this study, T&T was undergoing evaluation via Randomized Controlled Trial (RCT) and the evaluators also offered a list of evidence-based risk factors for teenage pregnancy to assist school staff with the selection of appropriate programme participants. Later during the evaluation, we discovered that staff responsible for selection rarely used either of these tools (Jessiman et al., 2011), but rather based their selection of potential programme participants on their documented and anecdotal knowledge of the student and/or their intuitive sense of the students' risk for teenage pregnancy (Sorhaindo et al., 2016; Jessiman et al. 2011, pg. 29).

Young women who were identified as at risk for teenage pregnancy were invited to attend an informational meeting where a representative from T&T described the programme. The potential programme participants were asked to complete a brief survey and were given personal and parental consent forms for the purposes of the intervention. T&T was described to the young women as an opportunity to gain expertise in working with young children and a National Award in Interpersonal Skills, Level 1 (NCFE). The young women were not told how or why they had been selected or about the programme's focus on teenage pregnancy. The personal and parental consent forms mentioned that the programme included information on sexual health, but did not state why they had been selected. Limited provision of information about the purpose of the programme and how participants were selected was a conscious effort by T&T and school staff to avoid stigma and to encourage young women to participate (Jessiman et al., 2011, pgs. 22-23).

**Evaluation Design**

Normally, outside of the RCT, the first 6-8 students submitting signed parental consent forms would be accepted onto the programme, but to enable the RCT, young women who were selected and returned the consent forms were randomised to either participate in the T&T intervention or to serve as comparisons. Comparisons were not offered any additional intervention. Data for the RCT were collected at three points in time via self-completion questionnaires: prior to random allocation (baseline), immediately following the intervention, and one year later. The specific measures, analysis and results of the RCT are published elsewhere (Bonell et al., 2013).

**Data Sources**

The qualitative data used in this analysis were collected during the RCT's integrated process evaluation conducted in four case-study schools based in four different boroughs of London with high rates of teenage pregnancy (Bonell et al., 2013; Jessiman et al., 2011). Table 1 provides a selection of socio-demographic characteristics for each of the boroughs included in the case study for the first year of the evaluation. In each case study school, data were collected from young women randomised to participate in the programme (intervention arm) and randomised to serve as controls (comparison arm), through focus groups, and paired and individual interviews. The first and fourth authors conducted four interactive focus groups with 20 participants overall, 8 paired or triad interviews with 18 young women overall, interviews with 15 programme participants and 8 interviews with comparison participants, two from each case study school (Table 2). Researchers used a step-wise process of increasingly more in-depth data collection techniques to build trust and rapport with the young women before conducting one-to-one interviews (Alderson & Morrow, 2004). Furthermore, this process allowed space for young women who were reluctant to participate in the larger group setting to more comfortably share their thoughts. The focus groups and interviews focussed largely on the participants' experience of and perceptions of recruitment, the acceptability, fidelity and impact of the programme, and possible causal pathways. The interviews conducted with the control participants (n=8) focused

on the potential for contamination and confounding, perceptions of the programme, the selection process and experience of and views on recruitment.

All the interviews and focus groups were conducted in private spaces on-site either at the school or at the nursery or primary school where the intervention was taking place. Semi- structured topic guides were developed to lead the discussions, which were conducted and recorded with permission, and later transcribed verbatim. Each interview lasted between 60-90 minutes and focus groups between 90 minutes and 2 hours. The research ethics committees of NatCen Social Research and the London School of Hygiene and Tropical Medicine (LSHTM) granted approval for the study.

**Analysis**

We adopted techniques associated with phenomenological and thematic analysis (Creswell, 2007). The first author read through the transcripts several times and took notes or highlighted sections of texts that appeared to represent some aspect of the young women's accounts of the experience of being targeted. These notes and sections of texts were written or printed onto small pieces of paper, reviewed separately from the transcripts and organised into emergent theme. The first and final authors then worked together to develop connections between the themes and grouped them into 'meaning units', including creating super-ordinate and sub-ordinate units. Finally, the first author coded the data line-by-line in NVivo using the previously created meaning units as a coding frame (Smith et al., 2009; Creswell, 2007), but undertook constant comparison analysis of the coding frame refining the meaning units and the codes during this process. When the text was coded in NVivo, the first author crosschecked the data by collection method (focus groups, paired interviews and single interviews) and noted any significant inconsistencies or deviant cases.

**Results**

**Characteristics of study participants**

We only collected year of study from the participants during focus groups and paired interviews. However, in one-to-one interviews with the same young women, researchers asked their age, ethnicity and information about whom they lived with. All were 14 years old, apart from one in School 4, and in either year 9 or 10. Most were from Black or mixed ethnicities (Table 3).

**Exploring experiences**

We present four aspects of participants' lived experiences of being selected for the T&T programme emerging from our data; two themes influenced by the targeting strategy: 'Confusion about why they were selected' and 'Increased resentment and mistrust of teachers' and two themes related to being categorised as at high-risk: 'Labelling and reinforcing stereotypes' and 'Managing risk reputations'.

**Confusion about reason for selection**

As the school and programme providers avoided informing the young women of the reason they were targeted for T&T, the majority of participants began the programme without knowing: that they had been identified as at risk for teenage pregnancy; and that the aim of the intervention was pregnancy prevention. Furthermore, almost all of the young women interviewed expressed confusion about how they were selected for T&T:

> *Do you have any idea why you were selected?*
>
> I don't know!
>
> *You have no… do you care?*
>
> What that I got picked?
>
> *Yeah, I mean about why, yeah. Coz not everybody went right, so…*
>
> No. I think coz I have older brothers and sisters, and… I don't know. I think maybe! And they have younger kids and then, yeah, I think so. But I'm not sure!
>
> *Interview 3, School 4*

In three of the focus group discussions and several of the interviews, the young women discussed their theories for how and why they were selected the programme, including choosing the most misbehaved students, teachers' choosing, having younger siblings, and their responses to the RCT baseline questionnaire. However, other young women believed that they had been selected randomly; and were happy about this: "Yeah, I was happy that I got chosen, 'cause it was random and not everyone got chosen so the fact that I did, yeah, I was happy about it." [Interview 3, School 1] These students did not understand that they were initially selected by their teachers to enter a pool of young women that were randomised for the RCT.

During the focus groups discussions, many of the young women expressed their existing doubt of teachers' trustworthiness.

> YW1: We think that they read the forms. They chose people according to the forms... But they said, like, everyone has an equal chance [but decided that] we're just going to pick out the names.
>
> YW2: Yeah, they said they were going to pick it out of a hat, but, like, they changed - I think, I think they did read them and decide for themselves.
>
> *Focus group, School 1*

> "After my friend told me, then I was kind of thinking that... I think a teacher *would* kind of do that, but I don't know." [Focus group, School 3]

**Increased resentment towards and mistrust of teachers**

Following this period of confusion, the purpose of the programme and the reason the young women were selected for the study became known to some young women via passing comments, rumours

and gossip at their school. For example:

> *Do you know why or how you got chosen to go to that room [where the informational meeting was held] ?*
>
> Nope.
>
> *Do you have any ideas?*
>
> There were just rumours and whatnot.
>
> *What were the rumours?*
>
> Erm, they picked the girls that are most likely to get pregnant.
>
> *Comparison interview 1, School 1*

Learning about the targeting strategy in this manner appeared to exacerbate negative feelings about their teachers:

> I didn't really like it, for teachers to think that […], you're going to get pregnant, they don't really know me outside of school, so I don't think like they have the right to actually say to me you're going to get pregnant, you have to go to this programme, you have to work with kids. […] So it's a bit like sad to hear that teachers think something like that about you. It's scary actually.
>
> *Comparison interview 1, School 1*

Some young women described feeling "insulted", "annoyed" and "angry" that their teachers believed them to be at risk for teenage pregnancy:

> They [other students] were like, 'Oh, you only got picked because you put you had sex [on the RCT baseline questionnaire]', and I was, 'No, I didn't' …
>
> *Did you believe them at all?*
>
> Yeah.
>
> *How did that make you feel when you were believing them?*

Annoyed and angry at the teachers that picked us.

*Interview 2, School 4*

For a few women, their latent mistrust of teachers was simply confirmed and perhaps strengthened through this experience.

**Labelling and reinforcing stereotypes**

For some study participants, particularly in one school, their perception of a predominance of young Black and Minority Ethnic (BME) women identified for the programme signalled T&T's focus on risk.

*Okay, so what about the girls that you saw [at the informational meeting] made you think [the programme was about teenage pregnancy]?*

Because they were all, like, black girls. So I just thought that it was, that it was that.

*Okay, does anybody else think that?*

Yeah

*In the school or in the group?*

In the group. At first we all did, but then, not now we don't.

*Okay, did it bother you at all?*

Not really.

*Interview 4, School 1*

The young BME women in this study not only appeared to be aware of this perception, but may have also internalised or accepted it.

For the participants in two of the schools, a preponderance of peers who had a reputation of being "loud" was another clue to the purpose of T&T: "[The informational meeting] was like most of the loud girls, but it's like most of the black girls, like a few Somali girls, and one Asian girl, but she

hangs around with the loud group." [Comparison interview 1, School 1]

When discussing why they may have been selected for T&T, the young women quoted below characterised their behaviours positively, yet at the same time appeared conscious of the incongruence of such behaviour with the expectations of their teachers and the school: "Because us lot are more outgoing, isn't it?" "Yeah". "If that make sense, we're really, like, straightforward about things". [Focus group, School 4]

In the focus groups, voices regarding dissatisfaction with being considered at risk were dominant. Only later, in more intimate settings, were opposing voices heard. For example, in a triad interview, it emerged that other young women in this study were indifferent about being considered by their teachers to be at risk of teenage pregnancy.

> *How do you feel that somebody might put you in a group of people that […] they think might have children when they're a teenager? How does that feel?*
>
> YW1: That feels insulting.
>
> YW2: I don't really mind.
>
> *You don't mind.*
>
> YW1: I would be insulted by that.
>
> *Triad interview, School 1*

A couple of the young women felt that labelling could encourage young people to participate in risky behaviour and that in fact information about sexual health and parenting would be useful for all young people.

> Putting tags on girls, 'cause they don't really know us outside of school, […] so they can't just tell us, you're going to be pregnant, we're trying to stop you from being pregnant.

That's gonna make the girls want to go and get pregnant.

*Comparison interview 1, School 1*

I think it should be for, good for all peoples, […], so then like they can all understand, because it could be anyone that, like needs, […], doesn't know what to expect or how to understand little kids. *Comparison interview 1, School 4*

Another young woman thought it would be hard to determine, based on assumptions about particular background characteristics, who would experience a teenage pregnancy:

... some people say like, 'Oh, children with bad families and that might get in that predic...' I think they can be the most quietest person and you would never know they get into that predicament, but I don't think it's any sort of person, I think anyone could really do it.

*Comparison interview 2, School 3*

**Managing risk reputations: distancing, silence and refusal**

Young women targeted for T&T appeared to employ three risk reputation management mechanisms in reaction to being identified as at risk for teenage pregnancy: distancing, silence and refusal. For example, one young woman in the control arm described feeling relief when she discovered that she had not been picked to participate in the T&T programme:

I was actually relieved.

*Relieved that you didn't get picked?*

Yeah, 'cause I thought they picked the girls that were like proper most likely to get pregnant, that's what I thought, ain't it, so, […] like wow they don't think that about me anymore.

*Comparison interview 1, School 1*

She was not aware that she had been randomly allocated to the control group. Albeit erroneous, she interpreted her *not* being selected to participate in T&T as a welcome indication that she was not in the same category as her *riskier* peers; she had avoided a potential loss of status by not being chosen, thus distancing herself from the associated stigma (Link & Phelan, 2001; Goffman 1959, 1963).

Though the young women were typically excited about participating in the T&T programme, (Sorhaindo et al., *in press*), some described how they managed the stigma associated with being labelled as at risk of teenage pregnancy by remaining silent about the programme's aim when talking about it with others, including their parents.

> *...what do you think your mum would think about that?*
>
> Mum would get angry.
>
> My mum would be really upset.
>
> Yeah, she'd be like, "What...?"
>
> *...so do you tell her?*
>
> And my dad would be upset...
>
> No, I didn't tell her, because then I don't really want my mum to be like, "Oh, well, you can't go there any more," 'cos my mum is that kind of person...
>
> I really want to do this.
>
> Yeah. So I just didn't tell my mum.
>
> *Focus group, School 3*

Some young women simply refused to accept that they were at risk of teenage pregnancy:

> I think the one where you got picked because you're more likely to have children soon, I think that's rude. 'Cause I know I'm not one of those people and I know like all of us that are there would not […]

*So why would you think it's rude?*

Because that means I'd be seen as a person that is most likely to have sexual intercourse at a young age, and I'm not.

*Single interview 2, School 1*

Others exhibited refusal by recasting the meaning of participation in line with their, less negative, self-perception. In an interactive activity where the young women were asked to fill-in-the-blank of a statement written on a card provided by the study researchers, one group changed their response:

> At first we wrote, what's it? [reading card] 'Girls that are vulnerable and gullible to get pregnant at a young age.' But then we realised that we're in the programme so this was talking about ourselves, and I'm not vulnerable. [Laughter.] So then we changed it to girls that are mature enough to know when it's right to have children'. *Focus group, School 3*

**Discussion**

Existing literature on targeting high-risk young people suggests that the approach can have unintended consequences (Evans et al., 2014; Wiggins et al., 2009; Bonell & Fletcher, 2008; Dishion et al., 1999). This study contributes to this literature by highlighting aspects of the experience of being targeted: feelings of confusion and resentment, the experience of labelling and reinforcement of stereotypes, and the need for additional identity work to manage risk reputations.

This study is limited by small sample size, as is common in qualitative research, and focussed only on London schools. Furthermore, though the lack of demographic information on the focus groups and paired/triad interviews participants somewhat limits our ability to contextualise the findings this information was collected from in-depth interviews with the same young women.

The study was also imbedded in a larger evaluation with a different aim and a complicated recruitment strategy. In fact, the RCT could have been responsible for some of the students' (and teachers') confusion about the targeting criteria and strategy. Finally, as about one-quarter of the young women who participated in T&T eventually dropped out mostly due to conflict with lessons or because they disliked the programme (Bonell et al., 2013), this study could have suffered from selection bias whereby the students with potentially less interest in school and more satisfaction with the programme remained. Despite these shortcomings, it provides insight into the experience of being targeted.

Many of the young women began the programme with lack of clarity regarding what the programme was for and why they had been selected to participate. They speculated about a number of potential reasons, and several expressed doubt regarding their teachers' honesty about the selection process. Learning that their teachers believed that they were at risk for teenage pregnancy and needed intervention left many young women feeling angry and mistrustful. Previous research by Evans et al. (2014) also found that inadvertent discovery of the targeting criteria led to negative labelling and bitterness among the intervention participants. Research on student disruption and teacher discipline in schools found an association between teachers who focussed on respect, personal regard and trust in their approach to discipline, and low student defiance; the relationship was mediated by students' perception of teacher trustworthiness (Schneider, Judy, Ebmey, & Broda, 2014; Gregory & Ripski, 2008). As positive relationships with teachers are important for learning, behaviour and overall wellbeing (Holfve- Sabel, 2014; Gorard & See, 2011; Gregory & Ripski, 2008), this experience could have wider implications.

Some study participants believed that the assessment of their risk for teenage pregnancy was based on prejudices related to their BME status and a negative interpretation of their outspoken character; and the characteristics of the women selected for the programme seemed to reinforce these existing stereotypes (Ferri & Conner, 2010; Archer, Halsall, & Hollingworth, 2007; Jackson

2006; Ali 2003). Half of the young women selected by their teachers and included in the RCT were from non-White ethnicities (Bonell et al., 2013). However, in only one of the four case-study schools was the overall proportion of students from non-White ethnicities close to this (45%). Only one-quarter of the students in two of the schools and 18% in the fourth school were non-White. Therefore, it is not surprising that the study participants observed that the proportion of young women from BME groups put forward by their teachers for participation in the intervention did not reflect the actual distribution of BME at their school.

The stereotyping of BME youth is pervasive in modern schools and young people's BME status is often "equated with failure and risk". As young white women co-opt this culture they are also similarly pathologised as hypersexualised 'problem girls' (Ferri & Conner, 2010; Ali, 2003). In an exploration of the 'ladette' culture among young women in the UK, Jackson (2006) points out how this modern departure from traditional and 'acceptable' forms of middle-class, and largely White femininity, signifies risk. From the perspective of the young people engaging in the culture, their posturing and behaviours were, in part, about protecting their self-image and presenting themselves more favourably (Goffman, 1959, 1963). However, in the school context, this further identified them as deviant and needing intervention (Jackson, 2006). Previous research suggests that young women in London secondary schools with low levels of achievement use strategies, including poor behaviour in the classroom, which they described as "being loud" and "speaking their mind", to challenge the quiet and passive feminine norms that are typically rewarded at school. Such behaviour often put the young women at odds with the school and was interpreted as deviant (Archer et al., 2007). Furthermore, "loud" behaviour from BME groups may reinforce stereotypes about Black students as belligerent (Archer et al., 2007; Fordham, 1993).

Young people may adopt a range of strategies to manage and control being considered 'at risk' (Mitchell et al., 2001). Several young women in this study felt it necessary to distance themselves from or reject risk identities. Silence is a common feature of stigma and risk management

strategies (van Brakel, 2006). The young women's concern about their parents' possible negative reaction to them being targeted for the T&T programme may have been warranted. In a focus group with parents (not related to young people participating in T&T), conducted during the formative evaluation phase of the larger project, some parents expressed concern that their children could be selected based on stereotypes, specifically related to ethnicity, and that there would be consequences associated with the 'at risk' label. Further, despite an awareness of the written guidance provided to teachers, they were skeptical about whether teachers would be objective and about teachers' competency for making sexual health risk assessments (Sorhaindo et al., 2009).

Some young women were indifferent to being targeted for intervention. Though it is difficult to interpret this, some possible explanations could be that, in the context of schools where categorisation and labelling are common, perhaps young women targeted for T&T were accustomed to being perceived as problematic and had come to accept this characterisation. Alternatively, this response could indicate the effects of labelling taking hold. Link and Phelan (2001) argued that individuals internalise social perceptions and beliefs about undesirable characteristics and thus anticipate rejection and discrimination (Sampson & Laub, 1997).

**Conclusion**

Targeting as a strategy for allocating resources towards prevention and treatment has its merits, potentially both in terms of equity and impact, if risk is not normally distributed. However, the approach may carry consequences that prevent interventions achieving their full benefit. The process of selecting young people for T&T led to negative emotion, potentially reinforced existing stereotypes and forced the participants to conduct additional identity work to manage the label imposed upon them. An alternative approach would be to include prospective participants in the process by informing them of the targeting strategy and/or inviting them to opt in based upon open

discussions and mutual assessments about their sexual health needs. Not only could this potentially prevent some of the negative experiences found here, but also, consciously engaging in an intervention to prevent risk behaviour may lead to increased adherence and intervention effectiveness, which may outweigh the costs of any reduction in participation. Otherwise, schools may introduce programmes that operate on the population-level, including all students, regardless of their risk. This approach would limit the unintended consequences of targeting and reduce incidence of teenage pregnancy, by lowering risk in the overall population.

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## References


Alderson, P., & Morrow, V. (2004). *Ethics, social research and consulting with children and young people*. Ilford, Essex: Barnardo's.

Ali, S. (2003). 'To be a girl': culture and class in schools. *Gender and Education*, *15*, 269-283. doi: http://10.1080/09540250303859.

Archer, L., Halsall, A., & Hollingworth, S. (2007). Inner-city femininities and education: 'race', class, gender and schooling in young women's lives. *Gender and Education*, *19*, 549-568. doi: http://10.1080/09540250701535568.

Arie, S. (2014). Has Britain solved its teenage pregnancy problem? *British Medical Journal, 348*. doi: http://dx.doi.org/10.1136/bmj.g2561.

Balfe, M., Brugha, R., O'Connell, E., McGee, H., O'Donovan, D., & Vaughan, D. (2010). Why don't young women go for chlamydia testing? A qualitative study employing Goffman's stigma framework. *Health, Risk and Society*, *12*, 131-148. doi: http://10.1080/13698571003632437

Bonell, C., & Fletcher, A. (2008). Addressing the wider determinants of problematic drug use: advantages of whole-population over targeted interventions. *International Journal of Drug Policy*, *19*, 267-269.

Bonell, C., Maisey, R., Speight, A., Purdon, A., Keogh, P., Wollny, I., Sorhaindo, A., & Wellings, K. (2013). Randomized controlled trial of 'teens and toddlers': A teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery. *Journal of Adolescence, 36*, 859-870. doi: http://10.1016/j.adolescence.2013.07.005.

Carey, G., & Crammond, B. (2014). A glossary of policy frameworks: the many forms of

'universalism' and policy 'targeting'. *Journal of Epidemiology and Community Health*. doi: 10.1136/jech-2014-204311.

Cerdá, M., Tracy, M., Ahem, J., & Galea, S. (2014). Addressing population health and health inequalities: The role of fundamental causes. *American Journal of Public Health*, *104*, S609-619. doi: http://10.2105/AJPH.2014.302055.

Creaney, S. (2012). Targeting, labeling and stigma: challenging the criminalisation of children and young people. *Criminal Justice Matters*, *89*, 16-17. doi: http://10.1080/09627251.2012.721967.

Creswell, J.W. (2007). *Qualitative Inquiry and Research Design* (2nd Ed). Thousand Oaks, London and New Dehli: Sage Publications.

Department for Children, School and Families (DCSF). (2010). *Teenage Pregnancy Strategy: Beyond 2010*. (DCSF-00224-2010). London: Department for Children Schools and Families.

Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harm. *The American Psychologist*, *54*(9), 755-764.

Evans, R., Scourfield, J., & Murphy, S. (2014). The unintended consequences of targeting: young people's lived experiences of social and emotional learning interventions. *British Educational Research Journal*, *41*, 381-397. doi: http://10.1002/berj.3155.

Ferri, B.A., & Connor, D.J. (2010). 'I was the special ed. girl': urban working-class young women of colour. *Gender and Education*, *22*, 105-121. doi: http:// 10.1080/09540250802612688

Fletcher, A., Gardner, F., McKee, M., & Bonell, C. (2012). The British government's Troubled Families Programme: a flawed response to riots and youth offending. *British Medical*

*Journal 344*, e3403. doi: http://dx.doi.org/10.1136/bmj.e3403

Fordham, S. (1993). "Those loud Black girls": (Black) women, silence and gender "passing" in the academy. *Anthropology and Education Quarterly, 24*, 3-32.

Foster, L.R., & Byers, E.S. (2013). Stigmatization of individuals with sexually transmitted infections: effects of illness and observer characteristics. *Journal of Applied Social Psychology*, *43*, E141-E152. doi: 10.1111/jasp.12036

Gregory, A., & Ripski, M.B. (2008). Adolescent trust in teachers: Implications for behavior in the high school classroom. *School Psychology Review*, *37*, 337-353.

Goffman, E. (1959). *The presentation of self in everyday life*. London: Penguin Books Ltd.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon & Schuster, Inc.

Gorard, S., & See, B.H. (2011). How can we enhance enjoyment of secondary school? The student view. *British Educational Research Journal, 37*, 671-690.

Grimes, D.A., & Schulz, K.F. (2002). Uses and abuses of screening tests. *The Lancet*, *359*, 881-84.

Holfve-Sabel, M.A. (2014). Learning, interaction and relationships as components of student well-being: Difference between classes from student and teacher perspective. *Social Indicators Research*, *119*, 1535-1555.

Institute for Fiscal Studies. (2013). *Teenage Pregnancy in England Center for Analysis of Youth Transitions Impact Study* (Report No. 6). London: Crawford, C., Cribb J., & Kelly E.

Jackson, C. (2006). 'Wild' girls? An exploration of 'ladette' cultures in secondary schools. *Gender and Education*, *18*, 339-360. doi: 10.1080/09540250600804966

Jessiman, T., Keogh, P., Scott, S., Wollny, I., Sorhaindo, A., & Bonell, C. (2012). Teens and

Toddlers integrated process evaluation. (Department for Education Research Report DFE-RR212).

Kneale, D., Fletcher, A., Wiggins, R., & Bonell, C. (2013). Distribution and determinants of risk of teenage motherhood in three British longitudinal studies: implications for targeted prevention interventions. *Journal of Epidemiology and Community Health*, *67*, 48-55. doi:10.1136/jech-2011-200867

Kreuter, M.W., & Wray, R.J. (2003). Tailored and targeted health communication: Strategies for enhancing information relevance. *American Journal of Health Behavior*, *27,* S227-S232.

Kreuter, M.W., Hovmand, P., Pfeiffer, D.J., Fairchild, M., Rath, S., Golla, B., & Casey, C. (2014). The 'long tail' and public health: New thinking for addressing health disparities. *American Journal of Public Health, 104*, 2271-2278. doi: 10.2105/AJPH.2014.302039

Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363-85.

McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *The ANNALS of the American Academy of Political and Social Science*, *587*(1), 16-30. doi: 10.1177/0002716202250781.

Mitchell, W.A., Crawshaw, P., Bunton, R., & Green, E.E. (2001). Situating young people's experience of risk and identity. *Health, Risk & Society*, *3,* 217-233. doi:10.1080/13698570124548

Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage Publications.

Rorie, M., Gottfredson, D.C., Cross, A., Wilson, D., & Connell, N.M. (2011). Structure and deviancy training in after-school programs. *Journal of Adolescence, 34*(1)*,* 105-117. doi: 10.1016/j.adolescence.2010.01.007

Rose, G. (1992). *Rose's Strategy of Preventive Medicine*. Oxford: Oxford University Press.

Sampson, R.J., & Laub, J.H. (1997). A life-course theory of cumulative disadvantage and the stability of delinquency. In T. Thorberry (Ed.), *Developmental Theories of Crime and Delinquency*. (pp.1-29). New Brunswick, NJ: Transactions Publishers.

Schneider, B., Judy, J., Ebmey, C.M., & Broda, M. (2014). Trust in elementary and secondary urban schools: A pathway for student success and college ambition. In, D. Van Maele, PB Forsyth, and M. Van Houtte (Eds.) *Trust and School Life: The Role of Trust for Learning, Teaching, Leading and Bridging*. Dordrecht, the Netherlands: Springer Science+Business Media.

Smith, J.A., Flowers, P., & Larkin, M. (2009) *Interpretive Phenomenological Analysis: Theory, Methods and Research*. London: Sage Publications.

SmithBattle, L.I. (2013). Reducing the stigmatization of teen mothers. *MCN. The American Journal of Maternal Child Nursing*, *38*, 235-241. doi: http://10.1097/NMC.0b013e3182836bd4.

Social Exclusion Unit (SEU). (1999). *Teenage pregnancy.* London: Her Majesty's Stationary Office.

Sorhaindo, A., Keogh, P., Bonell, C, Jessimen, P., Smith, R., & Wollny, I. (2009). Findings from pre-RCT formative evaluation of the Teens & Toddlers programme: Interim report for DCSF. Unpublished document.

Sorhaindo, A.M., Bonell, C, Fletcher, A., Jessimen, T., Keogh, P., & Mitchell, K. (2016)

How do teachers conceptualise risk for teenage pregnancy?: An exploration of the process of selecting "at risk" young women in schools for targeted prevention intervention. Unpublished manuscript, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.

Sorhaindo, A.M., Mitchell, K., Fletcher, A., Jessimen, T., Keogh, P., & Bonell, C. (in press). Young women's lived experience of participating in a positive youth development programme: The "Teens & Toddlers" pregnancy prevention intervention. *Health Education*.

Teens & Toddlers (2008). Teens & Toddlers Intensive Implementation Programme. Haringey. Unpublished internal document.

Van Brakel, W.H. (2006). Measuring health-related stigma – A literature review. *Psychology, Health & Medicine, 11*, 307-334. doi: 10.1080/13548500600595160

van Manen, M. (1990). *Researching Lived Experience.* Albany, NY: The State University of NY (SUNY).

Weimann, C.M., Rickert, V.I., Berenson, A.B., & Volk. (2005) Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health, 36,* 352.e1-352.e.7

Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M., & Weisz, J.R. (2005) Iatrogenic effects of group treatment for antisocial youth. *Journal of Consulting and Clinical Psychology*, *73*, 1036-1044.

Wiggins, M., Bonell, C., Sawtell, M., Austerberry, H., Burchett, H., Allen, E., & Strange, V. (2009). Health outcomes of youth development programme in England: prospective matched comparison study. *British Medical Journal, 339*, b2534. doi:10.1136/bmj.b2534

**Table 1**. *Selection of socio-demographic characteristics of London Boroughs where case studies were conducted*

| | |
|---|---|
| *% non-UK born, 2009* | |
| School 1 | 53.0 |
| School 2 | 38.8 |
| School 3 | 33.3 |
| School 4 | 28.2 |
| Greater London | 33.8 |
| United Kingdom | 11.4 |
| *% of population who are Black, Asian or Minority Ethnic (BAME), 2013* | |
| School 1 | 64.9 |
| School 2 | 50.2 |
| School 3 | 46.9 |
| School 4 | 39.6 |
| Greater London | 41.8 |
| England | 14.6 |
| Teenage conception rate, 2009 (per 1000 young people under 18) | |
| School 1 | 38 |
| School 2 | 37 |
| School 3 | 63 |
| School 4 | 59 |
| Greater London | 41 |
| England | 38 |
| *% of 16-18 year olds who are NEET*[*]*, 2009* | |
| School 1 | 4.6 |
| School 2 | 4.7 |
| School 3 | 8.7 |
| School 4 | 6.6 |
| Greater London | 5.3 |
| England | *not available* |

*Source*: London Data Store: http://www.data.london.gov.uk/dataset/London-borough-profiles

[*] A NEET is a young person who is "Not in Education, Employment, or Training".

**Table 2.** Summary of qualitative data collected

| | School 1 | School 2 | School 3 | School 4 | TOTAL |
|---|---|---|---|---|---|
| **Young people** | | | | | |
| Focus groups with participants (each including 5 young women) | 1 | 1 | 1 | 1 | 4 (n=20) |
| Paired/Triad interviews with participants | 1 x paired<br>1 x triad | 1 x triad | 2 x paired | 3 x paired | 8 (n=18) |
| In depth interviews with participants | 5 | 3 | 3 | 4 | 15 |
| In depth interviews with comparison participants | 2 | 2 | 2 | 2 | 8 |

**Table 3**. *Characteristics of study schools and interview participants*

| | Age at the time of interview | School year | Ethnicity | Family life |
|---|---|---|---|---|
| **SCHOOL 1*** | | | | |
| Interview 1 | 14 | 9/10 | Black or Black British | Lives with both parents; 4 brothers and two sisters |
| Interview 2 | 14 | 9/10 | Black or Black British | Lives with mother; two brothers and one sister |
| Interview 3 | 14 | 9/10 | Black Caribbean | Lives with mother; young brother and younger sister |
| Interview 4 | 14 | 9/10 | Black or Black British | Live with mother mum; has and older sister no longer at home; father has stepdaughter with girlfriend |
| Interview 5 | 14 | 9/10 | *No response*† | Lives with both parents and has four brothers and 1 sister |
| Comparison 1 | 14 | 9/10 | Black British | Lives with mother and six siblings |
| Comparison 2 | 14 | 9/10 | Black British | Lives with mother, father, sister and brother. |
| **SCHOOL 2** | | | | |
| Interview 1 | 14 | 9 | Mixed English | Has one sister *[No information on parents]* |
| Interview 2 | 14 | 9 | Asian | Lives with mother, two sisters, cousin and nephew. |
| Comparison 1 | 14 | 10 | Black British | Lives with mother, father, sister and brother; is the youngest child |
| Comparison 2 | 14 | 9 | *Data not collected* | Lives with mother and father and has 2 brother and 2 sisters; only one brother and one sister live with them |
| **SCHOOL 3** | | | | |
| Interview 1 | 14 | 9 | Black Caribbean | Lives with mother, sister and two nieces; and occasionally another niece comes to stay |
| Interview 2 | 14 | 9 | Polish | Only child and lives with mother and father. Emigrated from Poland to UK when she was 11. |
| Interview 3 | 14 | 10 | Black | Lives at home with 5 brothers and sisters, mother and stepfather |
| Comparison 1 | 14 | 9 | *Data not collected* | Lives with mother, grandmother and sister |
| Comparison 2 | 14 | 9 | Mixed Caribbean | Lives with mother, father and two brothers |
| **SCHOOL 4** | | | | |
| Interview 1 | 14 | *Data not* | White | Lives with mother, father, |

* Students moved from year 9 to year 10 within the same school year

† Respondent chose not to respond.

| | | | | |
|---|---|---|---|---|
| | | *collected* | | sister and brother |
| Interview 2 | 13 | *Data not collected* | White | Lives with mother, two younger brothers, and mother is expecting |
| Interview 3 | 14 | *Data not collected* | White | Lives with mother and stepfather; has two brothers |
| Interview 4 | 14 | *Data not collected* | White | One brother and one sister *[No information on parents]* |
| Comparison 1 | 14 | 9 | *Data not collected* | Lives with father and two sisters |
| Comparison 2 | 14 | 9 | *Data not collected* | Has an older brother and a younger brother *[No information on parents]* |